Patient Safety Overview

- Brief National Update
- DoD Initiatives
  - ✓ MTF PS Training
  - ✓ BTS Collaborative
  - ✓ MedMarx
- JC Standards
- AMEDD Patient Safety Program
  - ✓ Staff Introductions
  - ✓ Patient Safety Web Page
  - ✓ AHRQ Patient Safety Study

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Why the Focus on Patient Safety?

- Right thing to do
  - ✓ Saves lives, saves money
- Response to the “deadly secret”
  - ✓ IOM Report - To Err is Human
    - ✓ 44,000-98,000 deaths due to medical error
      - – 6th Leading Cause of Death
    - ✓ National Cost: $17-29 Billion/year
- Federal Mandate & Regulatory Requirement
  - ✓ Presidential directive, NDAA, DoDI, DoD IG
  - ✓ JCAHO & HCFA requirements
- IOM #2 (1 Mar 01) IOM #3

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Crossing the Quality Chasm: A New Health System for the 21st Century

- Recommends major redesign of health care system
  - Set of performance expectations for 21st century
  - Set of 10 new rules to guide patient-clinician relationships
  - Suggested organizing framework to better align incentives in payment & accountability w/ quality improvements
  - Key steps to promote evidence-based practice & strengthen clinical information systems
- 6 aims for improvement
  - ✓ Healthcare should be: safe, effective, patient-centered, timely, equitable

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Organizational Culture

- Organizational culture must be conducive to error prevention
  - ✓ We do not have a “healthy” culture in organized medicine
  - ✓ Hierarchical and authoritarian structures inhibit communication & effective problem solving
  - ✓ Errors are looked on as personal or professional failures (and are dealt w/ accordingly
  - ✓ We blame rather than problem solve

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Current Reality

- Error prevention is often hampered by:
  - ✓ Lack of clear lines of authority, accountability and responsibility
  - ✓ Fragmented approaches spread out over multiple bodies, committees, departments and individuals
  - ✓ Incidence of errors are severely under-reported due to:
    - ✓ Fear of reprisal
    - ✓ Ineffective and limited reporting/discovery mechanisms
    - ✓ Insufficient aggregate data to analyze and make decisions

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Resistance
"This is a Nursing Thing
"More work without the $ or staff to do it!"
"Just another program"
"They're watching me"
"This is the same thing we've been doing for years"
"Here comes another nurse with a clipboard"
Threat to Status Quo
Distrust
Fear
Blame
Threat to Ego
"Nobody's business"
"I'm too busy taking care of patients"
System Hierarchy
"not my job"
"More paperwork"
"No time"
CHANGE
"I'll get sued"
"They'll think I'm incompetent"

Moving…

Beyond Blame!

1-858-350-0100

Bridge Medical, Inc

120 South Sierra

Solana Beach, CA 92075

$10.00 Donation

THE VISION!

Process Design &

- ✓ Reduce Reliance on Memory & Vigilance
- ✓ Simplify
- ✓ Standardize
- ✓ Checklists
- ✓ Forcing Functions
- ✓ Eliminate Look and Sound a-likes

Organizational Change

- ✓ Integration
- ✓ Increase Feedback
- ✓ Teamwork
- ✓ Drive Out Fear
- ✓ Leadership Commitment
- ✓ Improve Direct Communication

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Creating A Safety Culture

- New approach accepts humans make mistakes, focuses on systems/processes and promotes openness
  - ✓ Leaders must empower all staff to take action to identify risk to prevent harm
  - ✓ Establish a non-punitive environment
  - ✓ Facilitate the importance of looking at near misses
  - ✓ Education and communication critical
    - ✓ Staff, patients, families, consumers

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Patient Safety and the Joint Commission

- Sentinel Event Policy since 1995
  - ✓To have a positive impact on improving care
  - ✓To focus attention on underlying causes and risk reduction
  - ✓To increase general knowledge about sentinel events, their causes & prevention
  - ✓To maintain public confidence in the accreditation process

JC Patient Safety Standards

- Effective July 2001
- Must have an effective medical/health care error reduction program
  - ✓ Includes ALL activities that contribute to maintenance/improvement of patient safety
- Leadership accountability
- Standards throughout JC manuals:
  - ✓ LD; PI; RI; HR; PF; IM; CC

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PS Standard Highlights

- Integrated Patient Safety Program
- Designate one or more qualified individuals or an interdisciplinary group to manage the program*
- Procedures for immediate response to errors*
- Clear systems for internal and external reporting (includes informing pts/families)*
- Annual report to governing body

* Requirement included in DoDI

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Leadership Responsibilities

- **Foster environment that encourages:**
  - ✓ Recognition and acknowledgement of risks*
  - ✓ Initiation of actions to reduce risks*
  - ✓ Internal reporting/analysis/actions taken*
  - ✓ Focus on processes and systems*
  - ✓ Minimization of individual blame*
  - ✓ Organizational learning about errors*

* Requirement included in DoDI

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MTF SE Management

- **Immediate Response Procedures**
  - ✓ Treat the patient
  - ✓ Contain the immediate risk to others
  - ✓ Preserve the evidence
- **Communication Procedures**
  - ✓ Internal Reporting
    - ✓ Commander/Senior Leaders
    - ✓ Patient Safety Program Manager
    - ✓ Patient/Family
  - ✓ External Reporting
    - ✓ MEDCOM w/in 72 hrs
    - ✓ JC w/in 5 days
    - ✓ AFIP Patient Safety Registry (future)

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MTF SE Management

- **Strategic Response Procedures**
  - ✓ Assign SE Response Team
  - ✓ Conduct Root Cause Analysis (w/in 45 days)
    - ✓ Ensure Focus on Process/System(s) NOT individuals
    - ✓ Use PI & Statistical Tools *(FOCUS-PDSA)*
  - ✓ Formulate and Implement Action Plan
    - ✓ Risk Reduction Strategies
  - ✓ Monitor Effectiveness of Action Plan

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JC Survey Process
SE Evaluation

- JC Policy
  - ✓ Survey Team does not ask organization for “list” SEs
- Assess compliance w/ PS standards
  - ✓ Review HCO SE policy
  - ✓ Interview HCO leaders on staff expectations, responsibilities for identifying, reporting & responding to SE
  - ✓ Establish if leaders received SE Alerts and are aware of their content

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JC Survey Process SE Evaluation

- SE "discovered" on-site surveyors evaluate if organizational SE policy followed
  - ✓ Evaluate if RCA/Action Plan acceptable
- If HCO has NOT fulfilled responsibilities
  - ✓ Surveyors will score relevant standards
- Surveyors will also review effectiveness & sustainability of HCO improvements in systems/processes from previous SEs

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JC "Proactive" Expectations of HCO

- Review each Sentinel Event Alert
- Consider suggestion contained in the SE Alert, as appropriate to HCO services
- Implement suggestions, or to implement reasonable alternatives, or to provide reasonable explanation for not implementing any relevant changes

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Why Report?

- Increase knowledge about potential harm, SE's & contributing causes
- Communicates intent to prevent
- Facilitates sharing lessons learned, successful prevention strategies
- Demonstrates MHS commitment to quality & creating culture of safety

It's the Right Thing to Do!

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“Near Miss” Report

A key component of improving safety is to proactively identify hazards that have the potential to result in harm. Your input is important to ensuring a safe environment for all. A “near miss” or ”close call” is defined as an event that could have resulted in harm to the patient, but did not, either by chance or timely intervention.

This is a “no blame” process of reporting potential hazards. Our goal is to focus on preventing and minimizing future risk. This is an opportunity to FIX the system before it breaks, recognize symptoms of broken processes, prioritize the level/extent of the inquiry and then recommend improvements.

THANKS for taking time out of your busy day to share youyourobservations and suggestions to improve patient safety! **This form can be filled out anonymously

Basic Information:

Location: _____

_____

Time: _____

Department(s) Involved in the Close Call_____

_____

_____

Originator: _____

I give permission to release my name & number to the person investigating the close call.

Yes _____ No _____

NOTE: Do not check this box if you want your name kept confidential.

Name: _____

E-mail: _____

Phone _____

Report of Incident:

Describe what happened. Include what the potential danger is/was. Could people have been hurt, could equipment have been damaged or mission affected? Attach additional sheets if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Corrective Action:

Please suggest any corrective actions or recommendations for improvement learned from this incident. Attach additional sheets if necessary.

_____
_____
_____
_____
_____
_____
_____
_____

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DoD Patient Safety Program (PSP)

- Centralized reporting and analysis of all events
  - ✓ AFIP – MHS Patient Safety Center
- Confidential and non-punitive focus
- “Near Miss” identification/reporting
- Standardized RCA & Aggregate Reviews
- Shared lessons learned

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DoD "Train-the-Trainer" PS Program

- Introduction to key safety concepts
- Overview of national efforts to reduce error
- Safety culture issues and strategies
- "Near Miss" Reporting
- Other "tools of the trade":
  - ✓ Safety Assessment Code (SAC)
    - ✓ Categorization of adverse events
  - ✓ Root Cause Analysis (RCA)
    - ✓ "Standardized" reporting format

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DoD Patient Safety "Pilot"

- Participating Organizations:
  - ✓ WRAMC, Ft.Belvoir, Ft. Meade, Bethesda, Nellis AFB
- Pilot Completed (Oct 00 – Mar 01)
- PSWG Plan:
  - ✓ Making improvements per MTF input
  - ✓ Funding Issues
- Outcome:
  - ✓ RCAs completed demonstrated lack of "systems" analysis

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AMEDD Recommendations

- Prioritize MTF training based on JC surveys dates
- Provide “formal” systems analysis training
- Participant “pre-work” and post-training requirements
- Incorporate additional curriculum items
  - ✓ JC Patient Safety Standards
  - ✓ Prospective Analysis
  - ✓ MEDCOM PS Policy Overview
  - ✓ MTF PSP Implementation Plan

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Other…AMEDD PS Initiatives

- Institute for Healthcare Improvement
  - Breakthrough Series Collaborative – Improving Safety in “High Hazard” Areas
- MedMARX
- MedTeams
- AMEDD PS “Strategy Plan”
- AHRQ Research Study Opportunity

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IHI Breakthrough Series Collaborative

- Improve safety in high hazard areas
  - AMEDD focus ICU and L&D
- Clinical team's aims include:
  - ✓ Reduce blood labeling errors (WAMC)
  - ✓ Improve MgSO4 administration process (LRMC)
  - ✓ Reduce decision to incision C-section time (both)
  - ✓ Reduce ventilator associated pneumonia (ICU)
- Article published in Feb ANC Newsletter

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IHI Breakthrough Series

Collaborative

- MEDCOM Administrative Team
  - Taped “near miss” re-enactment video (21 Feb 01)
  - ✓ Finalizing MgSO4 administration“change package”
    - ✓ CD-ROM
  - ✓ Pilot “change package” (Jun-July)
    - ✓ Ft. Hood, West Point volunteers
  - ✓ Refine package per pilot recommendations
    - ✓ Re-test package in additional MTFs, then
    - ✓ Promulgate to ALL MTFs with OB mission

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MedMARX

- Computerized medication error reporting system from the US Pharmacopoeia
- Currently available in ALL MTFs
- Allows anonymous comparisons with other facilities across the country and analysis of pooled data

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MedTeams

- Funds (1.4 mil) transferred to AFIP
  - ✓ Plan to hire 2 GS-15 for COE Directors
- DRC L&D product development proposed
  - ✓ MAMC & Beth Israel pilot sites
  - ✓ 8 Validation sites also being identified
    - Ft. Hood possible player
    - Recommend IHI sites be included (Bragg/LARMC)
- DRC recommends train-the-trainer concept to continue ER program
    - Training program scheduled for Aug 01
    - Funds cannot be used for travel per DRC

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Research Project Opportunity

- Research Grant submitted by JCAHO and US Pharmacopoeia
  - ✓ Soliciting 200 HCO to participate
    - ✓ 50 volunteers to date
  - ✓ MedMarx will be used to report errors
    - ✓ Year 1 – Medication related errors
    - ✓ Year 2&3 – Therapeutic, Diagnostic, Surgical/Anesthesia errors
- National Error Reporting DataBase

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AHRQ Patient Safety Research Project

- AMEDD invitation to participate
  - ✓ Opportunity for 1st JCAHO partnership
  - ✓ ALL AMEED MTFs have MedMarx “capability”
  - ✓ Recommend 10-15 MTFs to participate
- Assessing MTF expectations
  - ✓ Pharmacy and Nursing Quality Consultants
  - ✓ “Volunteer” MTF participation
  - ✓ Grant will fund MedMarx subscriptions x 3yrs
  - ✓ Data Analysis provided back to MTFs

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What's Ahead?

And…..What can you do now to facilitate patient safety in your organizations?

MEDCOM PS Program Initiatives

- MTF “Incident Reporting” Assessment
- PS Program Policy Guidance
  - ✓ DoD Instruction 6025.kk *(PS Web Page)*
  - ✓ AR 40-68 – Chapter 12 *(being staffed)*
  - ✓ Comprehensive MEDCOM PS Policy *(being developed)*
- AMEDD Balanced Score Card
  - ✓ PS metrics
- Corporate Policy Development
  - ✓ Surgical Site Verification *(2nd official revision)*

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MEDCOM PS Program Support

- "Train-the-Trainer" MTF Training
  - ✓ MEDCOM Funded
  - ✓ MTF Priority schedule will consider JC survey dates
  - ✓ Pre-work requirements
- Training currently being coordinated
  - ✓ TapRoot (13-14 Aug & 15-16 Aug/San Antonio)
  - ✓ DoD PS Training Program
    - ✓ Sept-Nov 01; Location(s) TBD
    - ✓ DCCS, PI, RM, Safety Officers, Pharmacy, Educators
    - ✓ Distance Learning Component (FY 02)

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MEDCOM Support

- QMD web site enhancement
- PS Educational Tools
  - ✓Trifolds
  - ✓PS Overview Briefs (Senior Leaders/Middle Managers/Staff)
  - ✓Video Re-enactments
  - ✓“Spread” Packages - BTS Successful Innovations

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The Future…

MEDCOM PS Team “partnership” w/MTFs to facilitate RCA completion

- ✓ Projected “start” date 1 Oct 01

- Comprehensive “web-based” “safety”/ “incident” reporting tool
- Organizational Risk Assessment Tools

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How Can YOU Assist?

- Champion PS as top organizational priority
- Foster a culture of safety
  - ✓ Encourage and reward reporting
  - ✓ Implement “Near Miss” Reporting Tool
- Proactively identify, manage & reduce risks
  - ✓ Review SE Alerts – share and implement strategies to prevent occurrence in your MTF
- Ensure RCA Teams are “truly” multidisciplinary & focus their efforts on systems and processes

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How Can YOU Assist?

- Evaluate current organizational structure
  - ✓ Facilitate integration and formal partnerships w/ QM/PI, RM, Safety, Ancillary Services
  - ✓ Are there things we can stop doing or collecting data on that is no longer needed?
- Participate in MedMarx implementation and data analysis
- Engage with IHI Collaborative Teams
- Share Ideas and Success Stories!

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QUESTIONS

- Has your MTF implemented the MedMARX program and who is entering the data & sending it to the USP database?
- Do you think your MTF would be interested in participating in the AHRQ/JC/USP research study?
- Are the PI, RM and safety officers, ancillary depts working together on ALL safety issues?

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Bottom Line

- **Leadership key to success!**
  - ✓ Must create a culture where health care workers feel secure & are rewarded for seeking and reporting errors
  - ✓ Culture of nursing and medicine must change from retribution to……

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"Important work with resources and time to participate it!"
"This is an important issue for all departments"
Leadership Support
"They're getting back with me"
" We've been doing this for years BUT now the focus is proactive NOT reactive!
"Here comes another clip board nurse encouraging us to - Report, Report, Report!"
Change the Status Quo
TRUST
NO Fear
Cooperation
Blame Free
System & Process Improvements
Value of "Near Miss" Reporting
"It's All of our job"
Participating in error reduction IS taking care of patients!
"Standardized" paperwork"
Systems Thinking
"I'll be thanked"
"Time provided"
Positive CHANGE
"They'll think I'm part of the solution"

REMEMBER….

Improvement takes time, good will, patience and insight…AND

Each of us can & will make the difference!

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Resources

- SE/Near Miss Management
  - ✓ DoDI - MHS Patient Safety Program
  - ✓ MEDCOM SE Policy/QMD Staff Officers
  - ✓ JC Sentinel Event Alerts
  - ✓ JC Sentinel Event Hotline - 630-792-3700
- Web Sites
  - ✓ JCAHO - www.jcaho.org
  - ✓ QM Directorate - www.cs.amedd.army.mil/qmo/
  - ✓ National Patient Safety Foundation - www.npsf.org
  - ✓ Institute of Safe Medication Practices - www.ismp.org

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THANK YOU!

Questions and/or Suggestions

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